reviews

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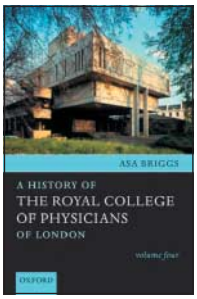
A History of the Royal College of Physicians of London, volume four (1948-1983)

Asa Briggs



Oxford University Press, £60, pp 498
ISBN 0 19 925334 X

Rating: ★☆☆☆

If ever there was a candidate for the dustbin of history at the outset of the NHS in 1948 it was the Royal College of Physicians of London. By then (the starting point for this fourth volume of its history) it had long outlived its initial guild conception. Nor was it an educational college in the modern sense, or a pressure group, or a specialty body, or a professionals' trade union. Renowned for its disdain of general practitioners as much as for its distrust of laboratory medicine, this 430 year old relic of medical elitism was ill fitted to the democratised new healthcare system—cordial and profitable though the negotiations had been between its then president, Lord Moran, and NHS architect Nye Bevan. Essentially a gentleman's club with a well stocked cellar, it was tucked away in a building at the corner of Trafalgar Square and Pall Mall East (better known then and now as Canada House)—its home since 1825. It was without a medical or a college secretary, and there was scarcely a woman to be found among its 767 fellows.

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By the end of Sir Douglas Black's presidency in 1983 (this volume's terminus), however, the college was a shiny relevancy on the world medical stage. In 1962, two years before its relocation to a state of the art concrete pile in Regent's Park and the publication of the first volume of its history, it scored a major media coup with *Smoking and Health*. It had made peace with the BMA and common cause with Britain's other royal medical institutions, revised its constitution, and opened its doors to more fellows than ever (more than 4000 by 1982, with a near equivalent number of members). Engaged with government on the future of medical education, it was also participating in a variety of health advisory bodies, royal commissions, and committees, and it had initiated some high profile ethical debates. In 1966 it launched its own journal. To be sure, it was still a "peculiar British institution"' and a bastion of privilege, but by the 1980s—with modern management structures in place serviced by an administrative staff of over 80—it exuded an ethos of Thatcherite corporate enterprise. The dinosaur was alive and kicking. Although women fellows were still thin on the ground and thinner still on its ruling "comitia," the college had a public presence as never before.

> It was still a "peculiar British institution" and a bastion of privilege

Much of this makeover was owing to the reformist drive, determination, and sometimes downright cunning of several of its eight presidents between 1948 and 1984. But as much was attributable to the college's increasingly felt need for effective public relations, especially as the post-thalidomide age of Illich and alternative medicine dawned. In 1972 the college established a public relations committee and hired a consultancy firm to advise it. By the 1980s, when press conferences became a regular part of the college scene, the RCP had effectively turned itself into a spin doctor for the profession as a whole, helping to keep an increasingly critical media-fed laity at bay—a hitherto unheard of concern for the college. Ironically, prominent among those exhorting the fellows to "respond positively to approaches from the media" (p 1269), was the former socialist and pacifist Charles Fletcher (1911-95), son of one of the most implacable opponents of the college in the interwar period, Walter Morley Fletcher, the first secretary of the Medical Research Council.

There was more to the survival-cum-awakening of the RCP than the cosmetics of public relations, however. Crucial, surely, was the inflation in medical qualification during the second half of the 20th century, a phenomenon driven by the need of hospital management committees at home and abroad for a means to discriminate between consultants for contract. Thus FRCP (fellow of the Royal College of Physicians), always a customary rather than a legal requirement for elite practice, became virtually a compulsory step on career ladders. The founding of other more specialised medical colleges in the 1960s and 1970s, although a source of friction in the RCP, did little to diminish this qualification monopoly. Simultaneously, of course, the college retained control over the main point of passage into medicine since the early 19th century (along with the MRCS (member of the Royal College of Surgeons)), the LRCP (licentiate of the Royal College of Physicians). Quite what this control and the degree inflation meant for the college's coffers, and hence for helping sustain its authority and relative autonomy, is an interesting question left unanswered by Lord Briggs.

Silence, too, reigns over the connection between the college's mounting interest in public relations and the commissioning and publishing of its own history—never mind its financial commitment to this venture. Volume four, though authored by an eminent historian and educationalist, is not a detailed—let alone critical—political narrative. Rather, like its predecessors (with whose pagination it is contiguous), it is largely an anodyne chronicle of the major events and personages connected with the college over the period covered, replete with appendices on college officials, bylaws, distinguished lecturers, prize winners, and so on. A chapter on smoking proves that this "very boring subject" (p 1370) need not be so, though more original and interesting—unsurprisingly, perhaps, in view of Briggs's recent multi-volume history of British broadcasting—is his chapter on how the college entered the "information society."

Briggs's patrons should be well pleased. Others with less investment in the ancient institution may find it tedious, despite Briggs's slightly jaundiced asides and his keen eye for the linguistic indices of change in postwar medicine and society—those signifiers of the transformations that were so effectively capitalised upon by the RCP in its remarkable reinvention of its own significance.

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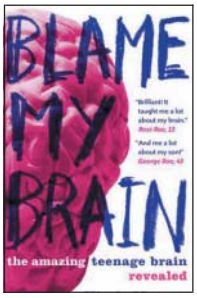
Blame My Brain: The Amazing Teenage Brain Revealed

Nicola Morgan



Walker Books, £8.99, pp 192
ISBN 0 7445 8368 3

Rating: ★★★★

Written for teenagers but invaluable reading for those coping with them—parents, doctors, and teachers—*Blame My Brain*, a guide to the biology behind teenage behaviour, is informative, accessible, interactive, and fun. There are self administered "tests," scientific explanations (including wonderful images of trees to depict brain development), useful advice about emotions, sleep, risk, and harmful behaviours, and guidance about websites and other sources of reliable information. I am a parent of three teenagers, and many of its stories about getting risk in proportion rang bells for me.

I heard author Nicola Morgan speak in Edinburgh last year about writing for teenagers, which is something she does well. She strongly disagrees with those who believe that acceptable writing for young people should be cleansed of sex, violence, and unpleasantness. Much better and healthier is it, she feels, to confront difficult issues on the safe pages of a book than for the first time in real life.

Although she states clearly that she is not a scientist, she is well qualified to communicate scientific material about "the amazing teenage brain." Her message to teenagers is subtle but clear: "You might even decide to respect your brain and treat it a bit better, once you know what's going on inside it."

For adults, connecting with teenagers is always a challenge. Knowledge gained as a parent can be useful as a doctor and vice versa. In the surgery a basic grasp of the language of skateboarding can serve to open doors. An awareness among parents of the practicalities of the local justice system can impress children avidly seeking information about friends and acquaintances in the court section of the local newspaper.

Most of us deal with adolescent patients and, although they probably make more attempts at civility with their doctor than their parents, the same tendencies for incivility and difficulty in communication are there. The stress of living with an adolescent, like any other personal stress, can affect the way we work. It's a cruel quirk of nature that, within a family, just as adolescent hormones are waxing, parental hormones may be very much on the wane. Adolescence and mid-life crises may coincide and this does not make for domestic bliss. *Blame My Brain* is pro-teenager without being anti-adult, sympathetic without being sentimental, sensitive and funny.

Our practice has a books-on-prescription scheme. The local library holds books on health related issues for us and we issue "prescriptions" for patients who are not library members. I am going to suggest that we get six copies of this book. In fact, maybe I'll suggest that we get a copy for every family in the practice.

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ART

LimeLight

An exhibition showcasing the work of the arts and health organisation Lime
CUBE (Centre for the Understanding of the Built Environment), 113-115 Portland Street, Manchester M1 6FB, from 10 to 29 October 2005
www.cube.org.uk
Admission free

Rating: ★★☆☆

How important are the arts in health care? As a medical student trudging from one cancelled teaching session to the next, I remember going out of my way to pass by a beautiful light installation in the drab hospital corridors—an uplifting moment in an otherwise stressful day. Lime—an arts organisation that has been working for over 30 years in healthcare settings in Greater Manchester—is showcasing some of its most recent work in this new exhibition. And anyone visiting the gallery will soon realise that the interface of art and health care isn't just about nailed down pictures on hospital walls.

This is an ambitious project as it combines work by professional artists, patients, and healthcare staff. It also involves a number of artistic media, including photography, prints, collage, film, sound installations, as well as sculpture and mosaics. Although there are some truly memorable and powerful pieces, the quality of work is extremely variable, and the lack of a coherent thread to the exhibition results in a whole that is—sadly—less than the sum of its parts.

All of the works are highly collaborative pieces. Suki Chan's *Flight* is a shimmering wave of fabric origami birds, which hangs in the entrance of Withington Community Hospital. The exhibition displays a scaled down version, but the sense of flight and freedom, as the translucent birds sway together, is maintained. Many of the 300 birds in the original piece were individually customised and decorated by patients, staff, and local schoolchildren.

Avril Clarke and Sharon Hall are artists who have personal as well as professional experience of mental illness. Through a series of workshops with women they produced *Keeping Well*, a mixed media piece, which includes a very moving series of digital prints showing self harm images and text describing thoughts of both hope and despair. The therapeutic aspect of this work came through participants being able to visualise triggers to mental illness and also help remind themselves of coping and protective factors.

Detail from *Keeping Well*

One of the less engaging pieces was Lucy Hunt's *Portraits of Pennine*, a series of black and white photographs of NHS staff in their place of work. Far from capturing "the people beneath the uniforms," this work reminded me of the bland photos of grinning colleagues adorning the "I do—so can you" posters encouraging hand washing on many UK wards. And the collage work *What Manchester Means To Me*, produced by members of Booth Hall Children's Hospital Youth Forum working with local businesses, while no doubt highly commendable given the artists' prior experience, fails to inspire or truly engage the viewer.

There is growing evidence that integrating the arts in health care can have beneficial effects on patient and staff wellbeing. However, dissenting voices are never far away. The British tabloid press has most recently run a number of stories grumbling about the money spent on hospital artwork. While the process of producing the work for this exhibition may well have been hugely beneficial to those involved, the finished product, in many cases, fails to have a similar impact.

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PERSONAL VIEWS

Why Kenneth Clarke is unfit to be Tory leader

Benjamin Disraeli, the father of modern Conservatism, wrote, "The first consideration of a minister should be the health of the people." Now, a prominent candidate for the Conservative Party leadership is Kenneth Clarke, deputy chairman of British American Tobacco (BAT).

BAT is the world's second biggest tobacco company, selling more than 850 billion cigarettes annually. Clarke is a central figure in the company, has been a well paid deputy chairman for seven years, and energetically promotes the company and its products around the world. He has been actively involved in BAT's efforts to undermine the tobacco control work of organisations such as the World Health Organization and the European Union.

He defends his company's activities with lines tobacco manufacturers have used for 50 years: "BAT did not want to sell their products to children and did not aim their products at children." This lacks credibility in London, let alone in developing countries, where children know little about the dangers of smoking but cannot miss BAT's aggressive advertising.

If he is elected, companies such as BAT will flourish with access at the highest levels

Clarke even (for an extra £25 000 ($44 035; €36 315)) became chairman of British American Racing, which in the words of BAT's advisers reaches "young people (who) are traditionally early adopters of new media capabilities and consequently a very receptive audience."

Clarke has supported the industry since his election in 1970 as MP for Rushcliffe, a tobacco constituency. Against the modest constraints proposed by David Owen as health minister in the mid-1970s he defended an "understandable exasperation growing on the part of the tobacco industry, which is manufacturing a lawful product . . ."

The 1979 election result seemed good news for tobacco control. Sir George Young, a junior minister for health, was committed to forceful action. But in September 1981 he was moved sideways, and shortly afterwards Clarke became minister for health. Far from opposing tobacco promotion, in July 1982 Clarke, as health minister, drove in the first race at the massively promoted Marlboro Grand Prix.

In December 1983 the *Observer*'s political editor, Adam Raphael, reported on "the cosy relationship that exists between Government and the tobacco industry." One example he cited was the Health Promotion Research Trust established by the government and tobacco industry to justify a feeble new voluntary agreement on tobacco advertising. The trust was funded by the tobacco industry. It was condemned by the medical establishment, but strongly supported by the minister. Raphael also quoted a letter from Clarke pressuring the chairman of the government funded Health Education Council "to soften its line on low tar cigarettes and actively to promote their use." Raphael wrote that this "bordered on the improper," and that "health ministers should not be promoting the interests of tobacco manufacturers."

Kenneth Clarke remained minister for health until 1985, returning to the portfolio as secretary of state from 1988 to 1990.

Until the early 1980s Britain was a leader in researching the harmful consequences of smoking, and quitting. The United Kingdom has continued to produce superb research, but Clarke's appointment to the health portfolio marked an end to the government's leadership role. Between 1983 and 2003 the prevalence of smoking in the United Kingdom fell from 35% to 27%. Over the same period prevalence in Australia, which in 1983 was slightly higher than in the United Kingdom, at 35.4%, fell to 17.4%.

Documents now available show that Clarke maintained contact and socialised with BAT and other tobacco companies during his ministerial career. In 1992, as secretary of state for education and science, he was lobbied by the Philip Morris company to oppose a proposed European directive. In accepting Philip Morris's invitation to the Formula One Grand Prix he wrote, "I remain happily opposed to the advertising and sponsorship ban being proposed by the [European] Commission. I will certainly do my best to ensure that our government maintains its opposition."

In July 1992, as home secretary, he appointed the chairman of BAT, Sir Patrick Sheehy, to be chairman of the inquiry into police responsibilities and rewards—hailed by BAT and Sheehy in a media statement as "a compliment to the [BAT] Group." Shortly after 1997, when labour came to power, Clarke was appointed to the BAT board.

There was a time when the conduct of tobacco industry leaders could be explained, if not excused. Many had started in the industry long before the first evidence on the dangers of smoking appeared. But Clarke started supporting and working for the tobacco industry many years after the dangers of smoking had been demonstrated beyond doubt by Sir Richard Doll and Sir Austin Bradford Hill, and confirmed by innumerable authoritative reports. Clarke himself noted in 1976 that "for some years we have known the effects that tobacco smoke can have upon health," and "the rather feeble attempts to dispute the scientific evidence have now petered out."

JOHN STILLWELL/EMPICS

Promoting tobacco: Kenneth Clarke

BAT knows that smoking kills one in two of its regular users, and is predicted to cause a billion deaths this century. With one sixth of the global market, BAT's products can already be credited with upwards of three quarters of a million deaths every year.

The tobacco industry comprises evil companies, promoting and selling a product they know to be lethal. Kenneth Clarke has been a supporter of the industry for over 30 years, and one of its leaders since 1998. Surely a peddler of death and disease has no place aspiring to lead the party of Disraeli, let alone a great country. If he is elected, companies such as BAT will flourish with access at the highest levels, while their products kill more and more millions in Britain and around the world.

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Competing interests: MD has been actively involved in campaigning for tobacco control since 1973.

A version of this article with references is available on bmj.com

Hunger striking prisoners: the doctors' dilemma

See *News*, p 866

News of further hunger strikes and force feeding at Camp X-Ray, the temporary US detention centre at Guantanamo Bay, Cuba, again brings into sharp relief the ethical debate on the position of doctors in a hunger strike by prisoners. A series of hunger strikes has occurred at the camp since it was opened, but they have gone largely unnoticed. What little coverage the media have given them seems to accept without question the right of prison authorities to force feed hunger striking prisoners against their will.

The World Medical Association, in its 1975 Declaration of Tokyo and again in the 1991 Declaration of Malta, prohibits the use of force feeding of hunger strikers. Details at Guantanamo Bay are predictably sketchy, but prison authorities seem to justify force feeding on the basis of preventing suicide. Any justification that is based on an assumption that a hunger strike is a form of prolonged suicide has been almost universally rejected. The aim of suicide is death. Hunger strikers do not want to die; they want to live. They want to live with a better quality of life—for instance through improvements in basic prison conditions, access to justice, or by making a political point for the greater good of society as they see it.

For many prisoners food refusal is their only weapon, given their background of a lack of basic human rights and legal representation and deprived of any other forms of protest. It is often the only way of bringing their protest into the public domain. Pressure is exerted on the authorities only when prisoners are at the brink of death or when deaths have occurred. Prisoners may not want to die but recognise that their aims may be achieved only through death.

The US authorities may continue to assert that holding prisoners at Guantanamo Bay without charge or trial or full access to legal representation is not an abuse of human rights. However, they know that if prisoners at Guantanamo Bay die on hunger strike the world's attention will suddenly focus on the camp in a way that it has not done before. Force feeding the prisoners—using the excuse of preventing suicide—is a cynical way to ensure that prisoners will not die. The prisoners' last weapon of protest has been taken away, and the world continues to tacitly collude with the US version of human rights.

Doctors in these circumstances have a dilemma. Their immediate superiors and the government assert their right to prevent suicide and maintain health and security within their prisons. The doctors' inclination is also to prevent death, particularly in an otherwise healthy person. On the other hand international medical authorities—as well as prohibiting force feeding—also promote the right of the individual to self expression: to protest as they wish and, crucially, to assert the right to refuse medical treatment.

Fundamental to doctors' responsibilities in attending a hunger striker is the recognition that prisoners have the same right as any other patient to refuse medical treatment. The doctor must establish that the prisoner on hunger strike is making that decision freely and has the capacity to make the decision to refuse medical treatment. Satisfied of this, doctors must resist coercion to treat patients against their expressed will. Doctors may not agree with the aims of the prisoner or the steps the prisoner is taking, but they must respect the prisoner's informed decision. Doctors do not have to agree that a decision by a patient to refuse a blood transfusion or refuse chemotherapy for a potentially treatable cancer is sensible or rational, but in law they do have to respect that patient's informed decision, even if it results in death. So it must be with the decision of the hunger striker.

> Doctors who participate in these practices need to examine their own consciences

Some governments and authorities have respected this position and allowed hunger strikers to die. This most famously occurred in Northern Ireland in 1980 and 1981 when 10 prisoners died. In South Africa in the 1980s and Turkey in the 1990s doctors have stood out against their government's declarations to force feed hunger striking prisoners and have refused to treat them.

Let us be under no illusion as to what force feeding means. Anyone who has tried to pass a nasogastric tube or insert an intravenous infusion into an uncooperative and confused postoperative patient knows how grim that can be. Force feeding against someone's will must entail force, restraint, or sedation. It does not conjure up a pretty picture. Doctors who participate in these practices need to examine their own consciences. But we must also recognise that such situations are not easy. How many of us would stand up as individuals against our immediate superiors and our governments in such circumstances? It is therefore incumbent on those in the wider medical profession to open their eyes to the situation, to open the ethical debate again, and put the spotlight on the US and its treatment of prisoners at Guantanamo Bay.

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SOUNDINGS

The flagon . . . with the dragon

It was more than just a heartsink consultation; it was tedious, nagging, grating, the kind of consultation that whispers the o'erwrought heart and bids it break. "You are in perfect health, Mrs Maguire," I repeated.

"Are you sure I'm all right?"

"I'm sure."

"Are you definitely sure?"

"Definitely."

"Are you absolutely definitely sure?"

"Absolutely."

"Are you absolutely definitely positively sure?"

"When was the last time someone actually hit you?" Of course I didn't say that; I was too busy gouging a scalpel into my left inner thigh and lapsing into my old defence mechanism of mumbling classic comedy sketches. "The pellet with the poison's in the vessel with the pestle, the chalice from the palace has . . . "

"I beg your pardon," she said sharply.

"I'm sorry," I said, "Did I say that out loud?"

"In any case," she said, "there's been a change; the chalice is broken, they've had to replace it with a flagon."

"With a flagon?" I said, surprised.

"With the figure of a dragon."

"The flagon with the dragon," I mused.

"Yes," she said, "The vessel with the pestle has the pellet with the poison, the flagon with the dragon . . ."

" . . . has the brew that is true," we shouted in unison, laughing and jumping up and down with excitement.

It was like being on the Road to Damascus while riding a bike for the first time and losing your virginity, all in one glorious blast; patients aren't one dimensional, I realised, they are real people with families, friends, lovers, jobs, passions. And Mrs Maguire's passion, I found out, was Hollywood comedies, pre-1960.

"Your proposition may be good . . ." I ventured.

" . . . but let's have one thing understood." She was right with me.

Then, altogether, "Whatever it is, I'm against it." We spent an agreeable last few minutes sparring over the relative merits of *Bringing Up Baby* and *The Man Who Came To Dinner*.

"By the way," she said, "I've an awful sore throat; can I have an antibiotic?"

I looked at her, a trifle disappointed; had our time together meant nothing?

"Only kidding," she said, deadpan.

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